Washington Township Dental
50 Years of Family Care

Adult Medical Update

474 Hurfville-Crosskeys Road Atrium
One, Suite A - Sewell, NJ 08080
856-582-1000

Patient Information

Full Name (last, first, middle): _____

SS#:_____

Home #: _____ Cell #: _____ Email: _____

HomeAddress_____

City: _____ State: _____ Zip: _____

Gender: M__ F __ Age: _____ Date of Birth: _____ Single __ Married __ Widowed __ Separated __ Divorced __

If Any Changes (below):

Dental Ins. Co.: _____ Subscriber Name:_____Subscriber DOB: _____

Subscriber Id#:_____

Insured Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Full-Time Student: Yes __ No __ Name of College: _____City & State: _____

In case of emergency who should be notified? _____ Phone: _____

Medical History

Physician's Name:_____ Date of Last Visit:_____

Have you had any serious illnesses or operations? ❑Y ❑N If yes, please describe: _____

_____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates: _____

✔ (Women) Are you pregnant? ❑Y ❑N ✔ Nursing: ❑Y ❑N ✔ Taking birth control pills? ❑Y ❑N

Check (✔) any of the following that apply:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints, Pins, Screws
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone treatments
- ❑ Cough, Persistent
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Problems
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ S.T.D.
- ❑ Stroke
- ❑ Surgery
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer

❑ Other: _____

Medications

List any medications being taken: (including aspirin, contraceptives, coumadin)

_____

_____

_____

_____

Pharmacy Name:_____

Phone: _____

Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Other:_____
- ❑ Penicillin
- ❑ Sulfa
- ❑ Anesthetic

_____

The above information is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility. We reserve the right to charge for appointments cancelled or failed without 24 hours advance notice. Weekdays after 4PM and Saturdays will automatically be charged. Payment is due in full at time of treatment unless prior arrangements have been approved. **Balances unpaid after 90 days are subject to a late charge of 1.5% per month,** and may be reported to the credit bureaus at our discretion. I understand that by signing below I accept financial responsibility for all charges whether or not paid by insurance.

_____ | _____

Signature of person responsible *Date*